

NYS EMT/AEMT Basic Life Support Protocols



2003 Edition



How to Use this Presentation

This presentation was developed to assist you in understanding the major changes and differences in the 2003 BLS protocols versus the 1997 BLS protocols.

We recommend that you have a NYS Certified Instructor assist your agency in reviewing and implementing these new protocols.

As you review this presentation you will need to have a copy of the 2003 protocols with you. The presentation refers back to specific pages and protocols within the book.



Regional Protocols

Regional EMS Councils throughout the state have the ability to develop regional protocols. Those protocols may differ from NYS State-Wide protocols, to serve the need of local and regional systems.

If your Regional protocol differs from NYS protocol, your **Regionally approved** protocol will supercede the NYS protocol.



Developed by the NYS EMS Bureau in conjunction with the NYS Emergency Medical Services Council (SEMSCO)

- Reviewed and approved by SEMSCO and the NYS Emergency Medical Advisory Committee (SEMAC)



New Protocols - New Style

- 3 hole punched, loose leaf book
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Updates available on our web page

<http://www.health.state.ny.us/nysdoh/ems/main.htm>

- Check often for updates!!



Protocol Book Distribution

- 100,000 copies printed
- 95,000 copies mailed to agencies & Course Sponsors
- Agencies must provide one copy to each member of their agency who holds NYS certification. If a member belongs to multiple agencies, only the member's primary agency should provide them with a copy.



Next Version

As of March 2003, the second version of the 2003 BLS Protocols have been developed and will be available soon.

Version 2 will be the same as version 1 and will also include any and all updates since the printing of version 1.



Protocol Implementation



st, 2003

- All agencies must have completed their in-service for their certified personnel by midnight of July 31st, 2003



Contents

- General Approach to Prehospital Patient Management
- Medical Protocols
- Trauma Protocols
- Special Considerations
- SEMAC Advisories and Bureau of EMS Policy Statements **NEW**
 - Appendices

Major Changes

- General Approach follows current patient assessment guidelines
- CUPS de-emphasized
 - CUPS is no longer required for testing purposes
 - CUPS may be taught and used, but not required
- Emphasis on early initiation of ALS intercept request

Anaphylactic Reactions M-3

- Use of patient's prescribed Epinephrine Auto Injector
- Use of agency owned Epinephrine Auto Injector under Medical Control guidance

Behavioral Emergencies M-4



Police should be present whenever restraints need to be used

Adult Cardiac Problem M-5

- Additional guidance for the use of patient prescribed Nitroglycerin
 - Tablets
 - Spray

Cold Emergencies M-6

- Classifications are:
 - Local Cold Injury
 - early or superficial
 - late or deep
 - Generalized Hypothermia
 - AED use for a maximum of three (3) shocks

Pediatric Respiratory Distress

M - 7

- Encompasses Croup & Epiglottitis
- Child respiratory distress defined
- Child respiratory arrest/failure defined

Heat Emergencies M-8



Classifications are now:

- Patients with moist, pale, normal to cool skin temperature

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Poisoning M-11

- Poison Control Centers removed from protocol
- Contact Medical Control to be used for treatment
- Activated Charcoal added

Adult Respiratory Arrest/Failure M-12

- Rates and volumes of artificial ventilations updated to meet AHA 2000 Guidelines
- Without supplemental oxygen: 700 - 1000 ml per ventilation
- With supplemental oxygen: 400 - 600 ml per ventilation

Use of an **FDA *approved*** Pediatric equipped AED is now allowed

- For use in Ventricular Fibrillation and Pulseless Ventricular Tachycardia only
- Continued shocks as long as the patient is still “shockable” according to the AED; no maximum number of allowable shocks

Respiratory Distress M-15

- Refer to protocol SC-4, Nebulized Albuterol for patients in respiratory distress with an exacerbation of their previously diagnosed Asthma
- Use of patient assisted multidose inhalers (MDI)

NEW

Stroke Protocol M-17

NEW

- For patients who have an acute episode of neurological deficit without evidence of trauma
- Advanced Life Support should be requested early without delaying patient transport to the nearest appropriate hospital

Stroke, con't

- Consider other causes for altered mental status, i.e. hypoxia, hypoperfusion, hypoglycemia, trauma, overdose
- It is important to establish the time of the onset of signs and symptoms
 - » Patient
 - » Family
 - » Bystanders
- **It is important to notify hospital personnel the time of onset of the patient's signs and symptoms!!**

Stroke, con't

- Perform Cincinnati Pre-Hospital Stroke Scale:
 - Assess for facial droop: show teeth or smile
 - Assess for arm drift: close eyes, hold both arms out straight for 10 seconds
 - Assess for abnormal speech: have patient say, "you can't teach an old dog new tricks"
- Transport patient to the nearest appropriate hospital

Burns (Chemical) T-3

- Stronger emphasis on the use of “Safe Zones”
- Decontamination of patient must be completed by appropriately trained personnel; no patients should be received in the Safe Zone until they are decontaminated

Burns (Thermal/Electrical) T-4

- For all burns, determine thickness and percent of body surface area (BSA) involved
 - Partial thickness burns less than 10% BSA:
 - Apply moist sterile dressings or moistened burn sheets to the burned areas
 - Full thickness burns & burns covering more than 10% BSA:
 - Apply dry sterile dressings or burn sheet to the burned areas

Burns, con't T-4

- Follow Regional Protocol for transportation of a burn patient to a Burn Center

Musculoskeletal Trauma T-5

- Traction splinting devices; criteria for and contraindications of
- Contraindications:
 - Injury is close to the knee
 - Injury to the knee
 - Injury to the hip
 - Injury to the pelvis
 - Partial amputation or avulsion with bone separation
 - Injury to the lower leg or ankle

Adult Major Trauma T-6

- CUPS removed from criteria
- Mechanism of Injury changes:
 - Patient struck by vehicle changed to any vehicle speed; no longer for vehicles moving at more than 20 mph
 - Vehicle collisions above 20 mph resulting in 12 inches of deformity to the vehicle added
 - Motorcycle crash added
 - Vehicle vs. bicycle collision over 5 mph added

T - 6, con't

- Physical Findings:
 - Glasgow Coma Scale raised from 13 to 14
- The entire Adult Major Trauma protocol is currently under review and will undergo a major revamping to reflect current national guidelines and NYS data analysis from Trauma Centers

T - 6, con't

- Further clarification and definition for the use of hyperventilation in patients with a suspected head injury.
- Consider Air Medical Transport per Regional Protocol - Do Not Delay Transport to the Appropriate Hospital

Pediatric Major Trauma T-7

- Vehicle pedestrian collision of “any” speed
- Vehicle collision defined as over 20 mph resulting in 12 inches of deformity to the vehicle
- Motorcycle crash added
- Vehicle vs. bicycle collision over 5 mph added

T - 7, con't

- Glasgow Coma Scale raised from 13 to 14
- Use of AED following AED protocol
- Full review of the Pediatric Major Trauma protocol is on-going and major changes are forecasted

NEW

Eye Injuries T-9

- New Protocol
- Stabilize impaled objects
- Eye contamination: irrigate with saline or water for at least 20 minutes, cover both eyes and do not delay transport
- Transport in Semi-Fowler position

Special Considerations

- Includes:
 - Oxygen Administration
 - Hypoperfusion (shock)
 - Emergency Childbirth and Resuscitation of the Newborn
 - Nebulized Albuterol **NEW**
 - Refusing Medical Aid (RMA) **NEW**

NEW

Nebulized Albuterol SC-4

- For patients between 1 and 65 years of age, with an exacerbation of their previously diagnosed asthma
- Agency must be approved by Regional EMS Council for the use of Nebulized Albuterol

Nebulized Albuterol, con't

- Request Advanced Life Support if available without delaying transport
- **Must** Contact Medical Control prior to administering to any patient with a history of Angina, Myocardial Infarction, Arrhythmia or Congestive Heart Failure

Nebulized Albuterol, con't

- Use of Borg Scale, peak flow meter, or other method must be used prior to administration of Albuterol
- Transport should not be delayed to begin or complete the treatment
- Dosage: Albuterol Sulfate 0.83%, one (1) unit dose in a nebulizer at an oxygen flow rate of 4 - 6 LPM

Nebulized Albuterol, con't

- Second administration of nebulized Albuterol may be administered if symptoms persist.
- A maximum of two (2) total doses may be given

RMA SC-5

- For patients who are refusing treatment and/or transport
- Two categories of patients:
 - Patients who are 18 YOA or older, or who are an emancipated minor, or is the parent of a child, or has married.
 - Patients who do not meet the above criteria are considered to be minors.
 - » Cannot give effective legal/informed consent
 - » Cannot legally refuse treatment
 - » Careful review of the entire protocol is necessary

RMA, con't

- Highlights:
 - Good thorough scene size-up and assessments
 - Particular attention given to level of consciousness (AVPU & GCS)
 - Obtaining a full set of vital signs every 5 - 10 minutes, when possible
 - Use of Law Enforcement and contacting Medical Control for assistance/advise

RMA, con't

- Documentation:
 - Complete a PCR for all patients who are refusing treatment and/or transport
 - Document scene and assessment findings
 - Review VII, A of the RMA protocol for documentation guidelines
 - MUST document that risks and consequences of the patient refusal were explained to the patient and that the patient understands them

Careful review of the entire RMA protocol is essential as well as your Regional and Agency regulations and policies regarding RMA



SEMAC Advisories and BEMS Policy Statements

- Inclusive of all pertinent SEMAC advisories
- Inclusive of many BEMS Policy Statements, which will assist the EMS provider in the use of certain protocols and patient care

Check our web site for updates to these documents



Appendices

- Pediatric vital sign norms
- New York State Trauma Centers
- Notes

The Future

The new design of the BLS Protocols allows the Bureau of EMS to update them on an as needed basis without having to wait for a new book to be reprinted.

Please check our web site often for any new updates or additions to the protocols.

Insert and/or remove any updated material from your copy of the protocols.

You are responsible to assure that your copy of the protocols are up to date

